THE ALTERNATIVE HEALTH CARE SERVICES TASK FORCE

SUB-COMMITTEE ON MIDWIFERY

SUB-COMMITTEE MEMBERS

Pat Farrell (Co-Chair)

Verna Sylvestre (Co-Chair)

Ian Macdonald

Maureen Morin

Helen Glass (Steering Committee Liaison)

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EXECUTIVE SUMMARY

The Alternative Health Care Services Task Force is supportive of legalizing the practice of midwifery in Manitoba, and has developed recommendations to that end. Several issues remain unresolved, but only because particular government departments and professional groups exist who would more appropriately resolve these issues. These issues include the development of programs to prepare midwives, planning for the integration of midwives into the health care system, and the development of appropriate frameworks for evaluation of the practice in the Canadian and Manitoba context. At present, however, the pool of qualified midwives currently residing in Manitoba are underutilized and are a viable alternative to existing expensive resources for family pregnancy health care.

INTRODUCTION

The Alternative Health Care Services Task Force was established by the Manitoba Health Advisory Network Steering Committee to review alternative health care systems appropriate to reduce expensive health care services without compromising quality of care. One of the potential alternatives cited was the practice of midwifery.

The process followed by the Task Force in developing this report included:

1. A review of major international studies and reports on midwifery, as well as reports on expanded health services.

2. Presentations from various interest groups in Manitoba. These groups are listed in Appendix A.

3. The development of recommendations for review by the Manitoba Health Advisory Network Steering Committee.

This report contains the findings and recommendations of the Alternative Health Care Services Task Force, on these issues. It is presented in three sections: 1) a description of midwifery; 2) statement of the problem; 3) recommendations.

A DESCRIPTION OF MIDWIFERY

The definition of midwifery adopted by the International Confederation of Midwives, The International Federation of Obstetricians and Gynecologists, and used by the World Health Organization is:

> [The midwife] must be able to give the necessary supervision, care, and advice to women during pregnancy, labour, and the postpartum period; to conduct deliveries on her own responsibility; and to care for the newborn and the mother. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help. [The midwife] has an important task in health counselling and education, not only for the patient but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynecology, family planning, and child care. [The midwife] may practice in hospitals, clinics, health units, domiciliary conditions, or in any other service.[1]

Out of the 210 World Health Organization member countries, Canada is one of eight that does not provide midwifery care (WHO Statistics).[2] In other jurisdictions, midwifery care has been shown to increase availability of prenatal care services, to lower infant mortality and morbidity, and to increase maternal well being among those populations characterized by poverty, geographical isolation, and other social factors (including teenage pregnancies), associated with poor obstetrical outcomes.[3].[4].[5] It is important to note from the outset, however, that the arguments in support of midwifery that are posed in this report are offered in full recognition of the limitations of existing scientific evidence. Indeed, the "statistical" evidence

offered in support of, or against the use of midwives fails to consider the full range of benefits to society of comprehensive, accessible health versus illness family pregnancy care. This report acknowledges the values-based argument as well as the limited scientific-based perspective.

Generally, there are three ways of practicing midwifery--as a physician licensed under the Medical Act, as a certified nurse midwife, and as a traditional midwife. The American Institute of Medicine, in its comprehensive study of ways to prevent low birth weights, examined the role of nurses as midwives:

> Certified nurse-midwives...have been shown to be particularly effective in managing the care of pregnant women who are at high risk of low birth weight because of social and economic factors. These health care providers tend to relate to their patients in a nonauthoritarian manner and to emphasize education, support, and patient satisfaction. For example, several studies have shown that women served by nurse-midwives are more likely to keep appointments for prenatal care and to follow specified treatment regimens.
>
> The committee recommends that more reliance be placed on nurse-midwives...to increase access to prenatal care for hard-to-reach, often high-risk groups. Maternity programs designed to serve high-risk mothers should increase their use of these providers; and state laws should be supportive of nurse-midwifery practice and of collaborations between physicians and nurse-midwives/nurse-practitioners.(6)

Legislation relevant to midwifery is contained in the Medical Act in Manitoba. In this Act, midwifery is viewed as a form of practicing medicine and is thereby restricted to licensed physicians (section of Act contained in Appendix B).

However, despite these legislative proscriptions, midwifery is still practiced by non-medical personnel, particularly in the Northern areas. In the Manitoba Advisory Council on the Status of Women Report on Midwifery, reference is made to the practice of midwifery both in northern outposts and hospitals. As well, the report states that an active contingent of midwives practice privately in most provinces--including Manitoba.(7) Recently, legislative changes necessary to permit the practice of midwifery are being pursued in Ontario.(8) Other Canadian jurisdictions (e.g.. B.C.), have mounted initiatives to test the validity of midwives' roles in the health care system (9).(10) In Alberta, a report by the Health Disciplines Board investigation of the Midwifery Final Report and Recommendations, recommended that midwifery be designated and regulated under the "Health Discipline Act". The Board also recognized that there are significant issues relating to this practice that require further study, and continued dialogue is necessary before implementation can proceed. Therefore, a multi-disciplinary Midwifery Services Review Committee will be established to examine issues requiring further investigation. This committee will also advise the Alberta Government on whether there are other appropriate legislative instruments to regulate the practice of midwifery.(11)

STATEMENT OF THE PROBLEM

There are four major considerations. The first is that the actual effectiveness and efficiency of midwifery as an alternative health service in Manitoba has not been determined. Currently, no full functioning, legal Canadian midwifery service models exist to evaluate in terms of cost effectiveness and efficiency. Data are needed not only in terms of outputs, but also outcomes in relation to the impact of midwifery in Manitoba.

However, the practice of midwifery in other countries has been evaluated as an effective and efficient alternative to physician delivered, low-risk obstetrical practice. Midwifery has also been evaluated as a useful adjunct to physicians in high-risk obstetrical practice. A report on the role of certified nurse midwives prepared by the Office of Technology Assessment, United States Congress, reads as follows:

> CNM's provide effective and low-cost maternity care to underserved, socio economically high-risk pregnant women and adolescents...CNM's have also improved access by adding to the scope of primary care services available to patients...
> ...Using CNM's rather than physicians to provide certain services would appear to be cost-effective from a societal perspective. (12)

A second consideration derives from the underutilization of existing, i.e. already trained personnel, and inappropriate and unnecessary use of expensive, specialized services. In Manitoba we have, in fact, a pool of approximately 75 educated and experienced nurse midwives whose practice is restricted to immediate antenatal and immediate postnatal services. The

full range of midwifery services as contained in the previously cited definition of midwifery (p. 3) is not being realized. This pool of qualified nurse midwives could be more appropriately used if they were allowed to practice in their full role--a role that promises integrated, comprehensive, health-oriented care.

In addition to nurse midwives, Manitoba has, like other provinces, a pool of experienced and variously educated traditional midwives who currently practice throughout the province. While their exact numbers are not known to this committee, six are members of the Manitoba Traditional Midwives Collective. It is not known how many babies are delivered yearly in Manitoba by traditional midwives. York estimates that in our neighboring province of Ontario about 50 midwives are delivering approximately 3000 babies per year.[13] The philosophy of the Manitoba Traditional Midwives Collective is that birth is a normal, healthy process, and should be treated as such. They provide pre- and post-natal care on a one to one basis with the birthing family. Many of these births are home deliveries, but traditional midwives will also attend families who experience hospital deliveries. Their emphasis is on continuity, low technology, and reliance on expert observational and other traditional skills.

Currently in Manitoba, the norm is to view pregnancy as obstetrical practice, which includes inappropriate use of expensive, specialized, obstetrical services for low-risk deliveries at a time when the majority of births do not

require this level of specialization. In 1988/89 there were 17,630 deliveries in Manitoba hospitals (appendix C). Of the approximately 12,066 deliveries in Winnipeg (appendix D), 71.8% were performed by obstetricians, and 28.2% by non-obstetricians. The proportion of high-risk deliveries in Winnipeg hospitals remains relatively stable from year to year at 35 to 39%.[14] Therefore, obstetricians in Winnipeg performed approximately 5,198 low-risk deliveries which, based on the WHO definition, could have been managed by midwives. The transfer of low-risk maternity care to midwives would require, in addition to legislation, changes in how physicians provide obstetrical care, the present physician fee structure, and the development of a mechanism for the payment of midwives. Indeed, it was concluded as early as 1972 by a joint committee of the Canadian Hospital Association, the Canadian Medical Association, and the Canadian Nurses Association, that the use of non-physicians in delivering babies would save at least $8.2 million per year and, projecting this estimate, is now close to $20 million per year.[15] In low density areas, and areas with low birth rates, there may be the need to have a different system for providing pregnancy care. Furthermore, more selective use of ultra sound scans and electronic fetal monitoring in pre-natal care, and a reduction in elective repeat caesarean sections have the potential for cost savings to the health care system. In B.C. it is estimated that 3,132 caesareans per year would

be avoided if elective, repeat caesareans were simply not scheduled--at a cost saving of approximately $10,598,688.[16]

A third issue derives from the differing needs for pregnancy health care within the province of Manitoba, based on geography and available resources. For example, some remote northern regions may be underserviced or inappropriately serviced. Anecdotal evidence forwarded by various interest groups suggests that women in the far north may avoid early prenatal care in order to avoid the risk of being transported to urban centers for high-risk prenatal care. The impact of early prenatal care, aimed at reducing the number of high-risk situations, is never adequately assessed. Furthermore, some geographic areas experience low birth rates while others experience relatively high birth rates, and these rates have remained relatively stable over the last five years (Appendix E). Thus, the nature of family pregnancy care that is required may vary geographically. Midwives may have different roles in these different areas, depending on need.

Finally, there is evidence that some family physicians and general practitioners are choosing not to practice obstetrics. A report commissioned by the Federal/Provincial Territorial Review on Liability and Compensation Issues in Health identified that both FP/GP and OB/GYN physicians across the country reported changes in the scope of their obstetrical practices during the last five years.[17] The report is based on a survey of 295 FP/GP physicians and 524 OB/GYN

physicians. The findings were that 36% of the OB/GYN respondents had indicated that they had stopped and/or reduced their obstetrical practice in the last five years. While 68.4% of the FP/GP physicians reported that they performed deliveries in 1983, this was reduced to 46.1% by 1988. The most dramatic decrease in FP/GP physicians who performed deliveries as part of their practice occurred in rural Ontario, where 45.3% indicated that they no longer did this as part of their practice, and 6.2% reported a decrease in the past five years. The four most influential reasons for stopping the practice of obstetrics were a desire for change in lifestyle (47.5%), concern regarding medical/legal liability (26.5%), not enough cases per year (23.1%), and inadequate compensation (21.4%). If the findings from this survey are correct, then it is conceivable that there will be a shortage of obstetricians and FP/GP physicians to provide obstetrical services in the future. This third issue, on the surface, could present a dilemma. If family physician-type obstetrical practice is decreasing, what would be the need for midwives? In the absence of scientific data in Canada, and in recognition that obstetrical care is not the same thing conceptually as midwifery care, it is argued that the use of a health oriented system, with emphasis on illness prevention and health promotion, could at least allow a system review. At present, only a narrow perspective of family pregnancy care--that is obstetrical care--gets factored into the health care system cost-benefit equation. Midwifery care, the

broader, potentially less expensive alternative, cannot be factored in because it is not legally recognized in Manitoba.

The fourth issue is related to the continuous demand for midwifery services by women in Canada and in Manitoba.[18],[19],[20] Canadian families are continuing to opt for alternative family pregnancy care outside of the obstetrical system. Consumer groups in support of midwifery exist in most provinces. Midwifery information hot lines are published, as is access to traditional midwives. While the numbers of families choosing this service may be small in relation to those using obstetrical hospital-based care, the concern is that consumers are not equally afforded a standard of safe care by the system. The legalization of midwifery practice would ensure that consumers (i.e. women, their families, and their babies) could be assured that all midwives licensed to practice meet the requirements for safe and effective practice. Thus, with the legalization of midwifery in Manitoba, women will have a choice in relation to pregnancy health care; a choice that is regulated and operated under government and professional standards.

RECOMMENDATIONS

The first recommendations are believed necessary to permit the practice of midwifery as an effective and efficient alternative to current obstetrical practice in the province of Manitoba. Currently, the practice of midwifery is restricted because of specific legislation. This includes the practice

of medicine, as stated in the Medical Act, and the prescription and use of selective medications, as contained in the Manitoba Pharmaceutical Act and the Food & Drug Act in Canada. It may be, that in the interests of evaluation, the required legislative changes to permit the practice could be negotiated with the agreement of all interested parties. In the United States, the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, and the Nurses Association of the American College of Obstetricians and Gynecologists, have issued a joint statement of Practice Relationships between Obstetrican/Gynecologists and Certified Nurse-Midwives (Appendix F). However, if midwifery is to be fully and safely integrated into the Manitoba Health Care system, and appropriately monitored, the following recommendations would need to be pursued:

1. Midwifery should be legalized in Manitoba as an insured health care service.

   (a) The legislation should make it possible for midwifery to be practiced in a full range of safe settings in Manitoba. This should include admitting privileges and access to specialty services, such as birthing centres.

   (b) A joint statement of practice roles and relationships between those who will be legally

permitted to practice should be developed by those vested participants.

2. A mechanism should be established for the payment of midwifery and for liability insurance for practice.

To address the issue of qualifications for immediate practice that would consider both the educational and experiential characteristics of Manitoba's existing pool of midwives, we propose:

3. That a council on midwifery be formed, including membership from the College of Physicians and Surgeons of Manitoba, the Manitoba Association of Registered Nurses, the Manitoba Traditional Midwives Collective, and health care consumers. The council would prescribe the educational and experiential requisites to practice midwifery in Manitoba, as well as the means of assessing these requisites.

Thus, it would not be necessary to await the development of special education programs in Manitoba for the education of professionals in this area; rather, the practice itself could first be evaluated in Manitoba and decisions could then be made at a later date about whether or not to invest further monetary and human resource in the development of education

programs. It would also permit the use of midwives educated elsewhere--for example, those midwives educated in the programs proposed in Ontario (Task Force on the Implementation of Midwifery in Ontario, 1987).

A second area for recommendations includes the question of whether midwifery should require previous registration as a registered nurse or whether it should be supported as a separate discipline. Models for both exist in various countries. In Canada, both Ontario and British Columbia are concerned that unless the issue of the traditional midwife is addressed in an inclusive manner, the public will not be protected. Indeed if, in Manitoba, legislation will only apply to nurse midwives, traditional midwives will continue to practice as they always have done. We strongly believe that pregnant families will continue to demand this choice. In the interest of effectiveness and efficiency, as well as in the interest of ensuring public safety, the following recommendation is posed so that it is clear what standards and practices will prevail, and what monitoring mechanism will be utilized:

4. **Midwifery should be regulated through a system of licensure so that only those midwives who are registered will be permitted to practice.**

This recommendation would require that midwives be registered with a professional licensing body. This body would then be responsible for the development and monitoring

of professional standards in relation to its practice. This is thought to be the most cost effective mechanism at the moment, which could quickly free existing midwives to practice as an alternative to expensive obstetrical services. Some inter-professional deliberations are required in the development of specific standards. For example, while the scope of midwifery practice should reflect the international definition of midwifery, it will be necessary to ensure that midwives be allowed to use and prescribe selected medications. This protocol should be clearly outlined by the governing body in appropriate standards.

The Task Force recognizes that there are significant issues related to the regulation of the practice of midwifery. Therefore, a continuing dialogue among the groups with vested interests will be required.

A final area for recommendations relates to the integration of midwives into the existing health care system in such a way that the public would be prepared for this service as a viable choice. This issue relates to questions about advertisement of services, as well as questions related to mechanisms to ensure public awareness for the introduction and use of midwives. At minimum, it is felt that some funding would be required to ensure public awareness. This, of course, would be dependent on whether midwifery would be introduced as a demonstration project for evaluation, or whether other integrative mechanisms are needed. In any case:

5. Appropriate mechanisms should be in place to ensure public preparation for the introduction and use of midwives.

Finally, since the model has been evaluated in other countries and is only beginning to be introduced in Ontario and British Columbia, an appropriate framework for the evaluation of the Manitoba model is required. For this reason, the following recommendations are forwarded:

6. Appropriate frameworks for the evaluation of the practice of midwifery in Manitoba must be developed so that its practice (including midwifery as an alternative health care service) can be evaluated in its full role.

7. A mechanism for inter-provincial collaboration on issues of integration of midwifery into the health care system and evaluation of its impact on family pregnancy health care should be established.

In summary, recent social forces are impacting on health care. Greater consumer participation in all areas of health care, the demand for more personal birth experiences, more sensitive health care professionals, and the decreased use of dehumanizing technology are all factors which have impacted on the increasing demand for the availability of midwives by the public. The inclusion of midwifery into the present system

will lead to improvement in the existing care options available to women; at the same time utilizing existing underutilized resources as a cost effective and efficient alternative to existing pregnancy health care service delivery.

GLOSSARY OF TERMS

Midwife:

- the international definition used by the World Health Organization defines a midwife as a person who, having been admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed a prescribed course of study in midwifery, and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

Certified nurse-midwives:

- registered nurses who have completed an additional educational program in midwifery. They are specialists in the care of healthy women and newborns. They also provide well-women gynecological care and family planning services.

Doula or birth attendants:

- attend the birth with the midwife and remain with the family up to two weeks to support the mother and newborn and provide care to the family. The emphasis is on continuity of care.

Lay midwives:

- people without recognized training who offer services to the birthing family on a fee-for-service basis. The training may range from informal apprenticeship to a variable length of training.

Traditional midwives:

- people without recognized training who provide pre- and post-natal care on a one to one basis with the birthing family. Their emphasis is on continuity, low technology, and reliance on expert observational and other traditional skills. Many of the births are home deliveries, but traditional midwives will also attend families who experience hospital deliveries.

Birth centre

- any facility, institution, or place, which is not an ambulatory surgical centre or hospital, or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

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APPENDIX A

1. Women's Health Clinic

2. Manitoba Association of Registered Nurses

3. Manitoba Council on the Status of Women

4. Kris Robinson, on behalf of the College of Physicians and Surgeons

5. Kris Robinson, on behalf of the Nurse Midwives Association

6. Manitoba Traditional Midwives Collective

7. Family X, delivered of a healthy baby by traditional midwife.

APPENDIX B

MEDICAL ACT

R.S.M. 1987, cM90

Persons deemed practicing medicine.

2(1) Without restricting the generality of the definition of practice of medicine, a person shall be deemed to be practicing medicine within the meaning of this Act who

(a) by advertisement, sign, or statement of any kind, written or oral, alleges or implies or states that he is, or holds himself out as being, qualified, able, or willing, to diagnose, prescribe for, prevent, or treat, any human disease, ailment, deformity, defect, or injury, to perform any operation or surgery to remedy any human disease, ailment, deformity, defect, or injury, or to examine or advise upon the physical or mental condition of any person; or

(b) diagnoses, or offers to diagnose, or attempts by any means whatsoever to diagnose, any human disease, ailment, deformity, defect, or injury, or who examines or advises upon, or offers to examine or advise upon, the physical or mental condition of any person; or

(c) prescribes or administers any drugs, serum, medicine, or any substances or remedy, whether for

the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury; or

(d) prescribes or administers any treatment, or performs any operation or manipulation, or applies any apparatus or appliance, for the cure, treatment or prevention, of any human disease, ailment, deformity, defect, or injury, or acts as a midwife; or

(e) acts as the assistant or associate of any person who practices medicine as herein set out.

Exceptions

2(2) The definition of practice of medicine does not include or apply to the practice of dentistry or pharmacy, or to the vendors of dental or surgical instruments, apparatus, or appliances,

(a) to a chiropodist acting within the scope of The Chiropodists Act;

(b) to a chiropractor acting within the scope of The Chiropractic Act;

(c) to a naturopath acting within the scope of The Naturopathic Act;

(d) to a nurse acting within the scope of The Registered Nurses Act, The Registered Psychiatric Nurses Act, or The Licensed Practical Nurses Act;

(e) to an ophthalmic dispenser acting within the scope of The Ophthalmic Dispensers Act;

(f) to an optometrist acting within the scope of The Optometry Act;

(g) to a physiotherapist acting within the scope of The Physiotherapists Act;

(h) to a person registered under The Psychologists Registration Act acting within the scope of that Act.

APPENDIX C

NUMBER OF DELIVERIES IN MANITOBA HOSPITALS

1982/83 TO 1989/90

MANITOBA HEALTH SERVICES COMMISSION

	Total Manitoba	Rural Manitoba	Brandon	Winnipeg
1982/83	16,435	4,845	985	10,600
1983/84	17,140	4,920	1,090	11,100
1984/85	17,130	4,865	1,150	11,090
1985/86	17,540	4,805	1,140	11,580
1986/87	17,420	4,550	1180	11,680
1987/88	17,210	4,320	1,260	11,620
1988/89	17,630	4,360	1,230	12,040
1989/90	17,885	4,415	1,220	12,250
* % change in 8 year period	+8.8%	-8.9%	+23.8%	+15.6%

** Deliveries include both live-borns and stillborns; also includes non-Manitobans delivered in Manitoba hospitals.

APPENDIX D

Schedule II (a)

WINNIPEG DELIVERIES BY OBSTETRICIANS - 1982/83 AND 1988/89

NUMBER OF OBSTETRICIANS

# of Deliveries	St. Boniface		MSC		Victoria		Grace		Misericordia		Total[1]	
	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89
1 - 5	7	4	4	9	3	5	2	1	4	5	0	17
6 - 25	1	1	4	-	3	1	3	1	2	2	4	1
26 - 50	3	-	2	-	-	2	-	1	1	2	7	-
51 - 75	-	-	2	-	1	2	-	-	-	1	2	1
76 - 100	-	1	2	1	-	-	1	-	-	-	4	1
101 - 125	1	3	-	1	1	-	-	-	-	1	-	4
126 - 150	4	-	2	2	1	-	1	-	2	-	4	2
151 - 175	2	2	-	2	-	-	-	1	-	-	4	3
176 - 200	1	2	5	1	-	1	1	-	-	-	3	3
201 - 225	3	2	1	3	-	1	-	1	-	-	4	5
226 - 250	1	-	1	3	-	-	-	-	-	1	3	4
251 - 275	2	1	1	3	-	-	-	-	-	-	4	4
276 - 300	-	-	1	-	-	-	-	-	-	-	1	1
301 - 400	1	1	1	1	-	-	-	-	-	-	3	2
401 - 500	-	3	-	-	-	-	-	-	-	-	-	3
510	-	-	-	-	-	-	-	-	-	-	-	1
531	-	-	-	-	-	-	-	-	-	-	1	-
598	-	-	-	-	-	-	-	-	-	-	-	1
Total	24	20	26	26	9	12	8	5	9	12	44	53
Deliveries by Obstetricians	2.845	3.538	2.954	3.350	346	651	437	443	349	502	7.082[2]	8.664
Deliveries by Non-Obstetricians	638	800	178	458	708	905	931	870	435	369	3.545[3]	3.402
Total Deliveries	3.483	4.338	3.132	3.988	1.054	1.556	1.368	1.313	784	871	10.627	12.066
% By Obstetrician	81.7%	81.5%	94.3%	88.5%	32.8%	41.8%	31.9%	33.7%	44.5%	57.6%	66.6%	71.8%

(1) The obstetricians may deliver in more than one hospital(hence this total column is not the sum of the numbers in each hospital). There are 18 obstetricians who performed 50 or less deliveries in all Winnipeg hospitals in 1988/89 (43 deliveries total for the 18). In 1982/83 there were 11 obstetricians who performed 50 or less deliveries.

The "average" obstetrician performed 246 deliveries in 1988/89 (eliminate the 18 who performed a total of 43 deliveries: hence 35 obstetricians performed 8.621 deliveries). Similarly, in 1982/83 the "average" obstetrician performed 204 deliveries.

(2) Includes 151 deliveries by 12 obstetricians at Concordia and Seven Oaks Hospitals.

(3) Includes 655 deliveries by 66 non-obstetricians at Concordia and Seven Oaks Hospitals.

SOURCE: Interim Report on Obstetrics to the Health Advisory Network by the Task Force on Winnipeg Hospitals Role Definition

WINNIPEG DELIVERIES BY NON-OBSTETRICIANS - 1982/83 AND 1988/89

NUMBER OF NON-OBSTETRICIANS

# of Deliveries	St. Boniface		MSC		Victoria		Grace		Misericordia		Total[1]	
	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89	82/83	88/89
1 - 5	26	34	20	22	27	40	7	13	20	25	81	78
6 - 10	13	7	7	2	5	9	4	6	7	8	35	21
11 - 15	8	10	-	2	3	4	8	8	8	3	38	28
16 - 20	2	2	-	1	6	2	11	8	2	6	24	21
21 - 25	2	7	1	-	5	3	5	3	3	2	18	13
26 - 30	-	4	-	-	3	1	1	4	3	-	9	11
31 - 35	3	3	-	3	3	4	2	3	-	-	8	13
36 - 40	2	1	-	1	1	-	1	1	1	-	6	6
41 - 45		1	-	-	-	-	4	1	-	-	7	3
46 - 50	1	1	-	-	-	-	-	-	-	-	1	1
51 - 55	-	-	-	1	-	-	-	1	-	-	1	3
56 - 60	-	-	-	-	-	2	3	-	-	-	4	1
61 - 65	1	-	1	-	1	-	-	-	-	1	1	2
66 - 70	-	-	-	-	-	-	-	-	-	-	1	-
71 - 75	-	-	-	-	-	3	-	2	-	-	2	3
76 - 80	-	-	-	-	-	-	-	-	-	-	-	1
81 - 85	-	-	-	-	1	-	-	-	-	-	2	1
98	-	-	-	-	-	1	-	-	-	-	-	1
165	-	-	-	1	-	-	-	-	-	-	-	1
Total	58	70	29	33	49	69	46	50	44	45	218	205
Deliveries by Non-Obstetricians	638	800	178	458	708	905	931	870	435	369	3,545[2]	3,402
Deliveries by Obstetricans	2,845	3,538	2,954	3,530	346	681	437	443	349	502	7,082[3]	8,884
Total Deliveries	3,483	4,338	3,132	3,988	1,054	1,586	1,368	1,313	784	871	10,627	12,086
% by Non-Obstetrician	18.3%	18.4%	5.7%	11.5%	67.2%	58.2%	68.1%	66.3%	55.5%	42.4%	33.3%	28.2%

(1) The non-obstetrician may deliver in more than one hospital (hence this total column is not the sum of the numbers at each hospital). In 1988/89 there were 78 non-obstetricians who performed 5 or less deliveries in all Winnipeg hospitals; 160 performed 25 or less and 192 performed 50 or less. There may be a few non-obstetricians who perform additional deliveries in rural hospitals.

(2) Includes 66 non-obstetricians who performed 655 deliveries at the Concordia and Seven Oaks Hospitals.

(3) Includes 151 deliveries by 12 obstetricians at Concordia and Seven Oaks Hospitals.

APPENDIX E

LIVE BIRTHS*

BY MANITOBA HEALTH & COMMUNITY SERVICES REGION 1984-1988

REGION	1984	1985	1986	1987	1988
Central	1525	1571	1546	1507	1535
Eastman	1076	1176	1151	1120	1052
Interlake	859	840	897	816	850
Norman	379	376	358	326	347
Parkland	564	526	504	514	434
Thompson	475	481	455	417	474
Westman	1780	1704	1696	1699	1669
Winnipeg	8575	8876	8964	9058	9194
I.R. & U.T.	1331	1445	1336	1390	1391
MANITOBA TOTAL	16564	16995	16907	16847	16946
Non-Resident	552	518	614	591	636
TOTAL	17116	17513	17521	17438	17582

SOURCE: Manitoba Vital Statistics Registrations.

* Infants born alive, excluding stillbirths.

AMERICAN COLLEGE OF NURSE-MIDWIVES

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FACTS ON

CERTIFIED NURSE-MIDWIVES

WHAT IS A CERTIFIED NURSE-MIDWIFE?

A certified nurse-midwife (CNM) is a registered nurse with advanced education in midwifery. To become certified, the nurse-midwife must complete a course of study in an accredited educational program and pass a rigorous examination administered by the American College of Nurse-Midwives (ACNM). State requirements for nurse-midwifery must also be met.

WHAT TYPES OF HEALTH CARE SERVICES CAN A CNM PROVIDE?

Nurse-midwifery practice includes services to normal healthy women and their babies in the areas of:

- Prenatal care
- Labor and delivery management
- Postpartum care
- Well-woman gynecology
- Normal newborn care

HOW ARE CERTIFIED NURSE-MIDWIVES EDUCATED?

Today, 24 major colleges and universities across the United States offer either certificate, masters or doctoral degree programs in nurse-midwifery. These programs are accredited by the ACNM Division of Accreditation, which is recognized by the U.S. Office of Education.

Nurse-midwifery students are registered nurses and most have had extensive prior experience in maternity and public health nursing. A student nurse-midwife receives extensive instruction in clinical midwifery and advanced education in normal obstetrics/gynecology and newborn care.

HOW SAFE IS DELIVERY BY A CERTIFIED NURSE-MIDWIFE?

Over the years, nurse-midwives have maintained a superb record of safety and client satisfaction. Research shows that a woman experiencing a healthy pregnancy, labor and delivery is as safe in the hands of a nurse-midwife as she would be in the hands of a physician. A recent report by the Institute of Medicine points out that nurse-midwives are particularly effective in managing the care of pregnant women, and that such care results in fewer premature and underweight babies.

DOES MEDICAL INSURANCE COVER NURSE-MIDWIFERY CARE?

Nurse-midwifery services are covered by most private medical insurance carriers. In addition, nurse-midwifery services are also covered under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicaid and Medicare.

WHERE DO CERTIFIED NURSE-MIDWIVES WORK?

Today, more than 2700 certified nurse-midwives practice in all 50 states and in many other countries around the world.

Nurse-midwives typically work in hospitals, birthing centers, health maintenance organizations, public health departments, private practices and clinics. Usually, nurse-midwives deliver babies in hospitals or birthing centers. Some nurse-midwives deliver babies in the home if certain safety criteria are met.

WHAT IS THE AMERICAN COLLEGE OF NURSE-MIDWIVES?

The American College of Nurse-Midwives is the professional organization of certified nurse-midwives. It is autonomous and speaks for its membership on issues affecting the education, practice, recognition, legislation and economics of nurse-midwifery. ACNM is also the accrediting organization for nurse-midwifery education programs and administers the certification exam for nurse-midwives. ACNM was incorporated in 1955 in New Mexico.

HOW MUCH DO CERTIFIED NURSE-MIDWIVES EARN?

According to a 1986 ACNM membership survey, the average salary of a certified nurse-midwife is $30,936. The earnings of a nurse-midwife vary widely and depend upon such factors as place of employment, scope of practice, education, and years of experience.

WHICH STATES HAVE THE MOST CERTIFIED NURSE-MIDWIVES?

California claims the most certified nurse-midwives with approximately 400 CNMs. It is followed by New York, Florida, Pennsylvania, Illinois, Maryland, Massachusetts, Texas, Ohio and Georgia, respectively.

According to the National Center for Health Statistics, in 1985 14 states and the District of Columbia reported over four percent of all births were attended by certified nurse-midwives.

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CONTRIBUTIONS OF CNMs TO IMPROVED HEALTH OUTCOME

CNM's outstanding contributions to the prevention of low birthweight have recently been highlighted by three separate groups: the National Academy of Science's Institute of Medicine,[6] the Southern Governors' Association Task Force on Infant Mortality,[7] and the Children's Defense Fund.[8]

The Institute of Medicine's Report Preventing Low Birthweight, as part of its emphasis on improved access to prenatal care, calls for "more reliance...on nurse-midwives...to increase access to prenatal care for hard-to-reach, often high-risk, groups. This recommendation is based on the studies that indicate that certified nurse-midwives can be particularly effective in managing the care of pregnant women who, because of social and economic factors, are more likely to deliver low birth weight babies.

The Southern Governors' Association Task Force on Infant Mortality echoes these recommendations, as does the Children's Defense Fund's Manual on Providing Effective Prenatal Care Programs for Teens.

A number of studies have been done which show that care by certified nurse-midwives increases utilization of prenatal care facilities and that such care reduces the incidence of low birth weight, prematurity and neonatal death and reduces the impact of risk factors, to wit:

- In Holmes County, Mississippi, in 1971 the infant mortality rates had dropped from approximately 38 per 1,000 live births to 20 per 1,000 live births, two years after certified nurse-midwives began providing primary care to pregnant women as part of a community-wide focus on the health problems of mothers and babies.[1]

- In a pilot project in Madera County, California, established by special legislation which made nurse-midwives legal for the duration of the project, certified nurse-midwives were introduced as the only new variable in the County's health care system. From January 1961 to June 1963 the prematurity rate dropped from eleven percent to 6.6 percent and the neonatal mortality rate dropped from 23.9 deaths per 1,000 live births to 10.3 deaths per 1,000 live births. There was a significant increase in attendance at prenatal clinics during the pilot project. After the program was discontinued due to the California Medical Society's opposition to legalizing nurse-midwifery, the prematurity rate increased by almost 50 percent and the neonatal death rate for mothers who had no prenatal care almost doubled after the program ended. The neonatal death rate of mothers who began prenatal care in the first two trimesters increased fourfold.[2]

Page Two--Contributions

- Between 1976 and 1977 at a clinic for teenagers in Lincoln Hospital in New York City, nurse-midwifery care brought considerable improvement in outcome measures such as maternal weight gain and hematocrit. The rate of low birthweight babies ropped from 18.1 percent to 6.3 percent.[3]

- At Su Clinica Familiar in southern Texas, where all maternity care for normal mothers is provided by certified nurse-midwives, the prematurity rate in 1974, two years after nurse-midwifery care began, was 3.5 percent. In the same year in Texas the prematurity rate was 7.6 percent and for the nation it was 7.4 percent.[4]

- A study by the University of Mississippi Medical Center between October 1, 1972 and April 30, 1973 showed that nurse-midwifery clients kept 94 percent of scheduled appointments, compared with 80 percent of visits kept by clients of the house staff physician. It should be noted that clients of both physicians and nurse-midwives did not see the same care providers at successive visits.[5]

1. Marie C. Meglen, "A Prototype of Health Services for Quality of Life in a Rural County," Bulletin of Nurse-Midwifery, XVII, No. 4 (November 1972): 103-113.

2. Barry S. Levy, Frederick S. Wilkinson and William M. Marine, "Reducing Neonatal Mortality Rate with Nurse-Midwives," American Journal of Obstetrics and Gynecology, 109 (January 1, 1971): 51-58.

3. M. Brenda Doyle and Mary V. Widhalm, "Midwifing the Adolescents at Lincoln Hospital's Teen-Age Clinics," Journal of Nurse-Midwifery, Vol. 24, No. 4 (July-August, 1979): 27-32.

4. Sr. Angela Murdaugh, "Experiences of A New Migrant Health Clinic," Women and Health, Vol. 1, No. 6 (November-December, 1976): 25-28.

5. C. Slone, H. Wetherbee, M. Daly, K. Christensen, M. Meglen and H. Theide, "Effectiveness of Certified Nurse-Midwives," American Journal of Obstetrics and Gynecology, 124 (January 15, 1976): 177-182.

6. National Academy of Sciences, Institute of Medicine, Preventing Low Birthweight, National Academy Press, Washington, D.C. 1985 p. 161.

7. Southern Regional Task Force on Infant Mortality, Interim Report, Southern Governors' Association. February 24, 1985.

8. Rosenbaums, Sara, The Children's Defense Fund's Adolescent Pregnancy Prevention/Prenatal Care Campaign, Washington, D.C. 1985.

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WHAT DO LEADING POLICY ORGANIZATIONS AND REPORTS SAY ABOUT CARE BY CERTIFIED NURSE-MIDWIVES?

INSTITUTE OF MEDICINE

In its comprehensive study of ways to prevent low birthweight, the Institute of Medicine writes:

> Certified nurse-midwives...have been shown to be particularly effective in managing the care of pregnant women who are at high risk of low birthweight because of social and economic factors. These health care providers tend to relate to their patients in a nonauthoritarian manner and to emphasize education, support, and patient satisfaction. For example, several studies have shown that women served by nurse-midwives are more likely to keep appointments for prenatal care and to follow specified treatment regimens.
>
> The committee recommends that more reliance be placed on nurse-midwives...to increase access to prenatal care for hard-to-reach, often high-risk groups. Maternity programs designed to serve high-risk mothers should increase their use of these providers; and state laws should be supportive of nurse-midwifery practice and of collaborations between physicians and nurse-midwives/nurse-practitioners.
>
> (Source: Institute of Medicine. Preventing Low Birthweight: Summary. Washington, DC: National Academy Press, 1985, p. 23.)

OFFICE OF TECHNOLOGY ASSESSMENT

In its evaluation of certified nurse-midwives and other non-physician providers prepared for the Senate Committee on Appropriations, the Office of Technology Assessment writes:

> The weight of the evidence indicates that, within their areas of competence,...CNMs provide care whose quality is equivalent to that of care provided by physicians. Moreover,...CNMs are more adept than physicians at providing services that depend on communication with patients and preventive actions...Patients are generally satisfied with the quality of care provide by... CNMs, particularly with the interpersonal aspects of care...
>
> Historically,...CNMs have been credited with improving the geographic distribution of care, because many of them have been willing to locate in underserved rural and inner-city areas...These practitioners will continue to play valuable roles in underserved areas.
>
> ...CNMs increase access to primary care in a wide variety of nongeographic settings and for populations not adequately served by physicians. ...CNMs provide effective and low-cost maternity care to underserved, socioeconomically high-risk pregnant women and adolescents...CNMs have also improved access by adding to the scope of primary-care services available to patients...
>
> ...Using...CNMs rather than physicians to provide certain services would appear to be cost-effective from a societal perspective.
>
> (Source: United State Congress, Office of Technology Assessment. Nurse Practitioners, Physicians Assistants, and Certified Nurse-Midwives: A Policy Analysis. Washington, DC: U.S. Government Printing Office, 1986, pp. 5 - 6. [Health Technology Case Study 37])

BOSTON WOMEN'S HEALTH BOOK COLLECTIVE

In its handbook on health-promoting, woman-centered health care, the Boston Women's Health Book Collective writes (and emphasizes by using capital letters):

> STUDIES OF NURSE-MIDWIFERY PRACTICE, PAST AND PRESENT, CONSISTENTLY SHOW OUTCOMES AS GOOD OR BETTER THAN PHYSICIAN OUTCOMES, WITH FEWER FORCEPS DELIVERIES, CESAREAN SECTIONS AND EPISIOTOMIES, FEWER STILLBIRTHS AND LOW-BIRTHWEIGHT BABIES.
>
> (Source: The Boston Women's Health Book Collective, The New Our Bodies, Ourselves. New York: Simon & Schuster, Inc. 1984, p. 337.)

C. ARDEN MILLER, NATIONAL LEADER IN HEALTH POLICY

In his study of the lessons we in the United States might learn from European maternity care systems, C. Arden Miller (professor, pediatrician and former president of the American Public Health Association) recommends for U.S. policy:

> The role of midwives deserves special attention. They play a crucial role in the maternity care in Europe, especially as members of hospital-based maternity teams. Midwives are known to render services that are of high quality, economy and comprehensiveness--attributes that do not always characterize obstetric care.
>
> (Source: Miller, C. Arden. Maternal Health and Infant Survival: An Analysis of Medical and Social Services to Pregnant Women, Newborns and their Families in Ten European Countries, with Implication for Policy and Practice in the United States. Washington, DC: National Center for Clinical Infant Programs, 1987, p. 30.)

MASSACHUSETTS TASK FORCE ON PREVENTION OF LOW BIRTHWEIGHT AND INFANT MORTALITY

In its report on ways to improve the health of Massachusetts infants, the Task Force on Prevention of Low Birthweight and Infant Mortality recommends:

> Expand use of mid-level health professionals, especially nurse-midwives, through third-party reimbursements and support through public health contracts.
>
> (Source: Task Force on Prevention of Low Birthweight and Infant Mortality...Closing the Gaps: Strategies for Improving the Health of Massachusetts Infants; Report to the Massachusetts Department of Health; Executive Summary. May 1985, p. 6. [14199-10-1000-10-85])

GENERAL ACCOUNTING OFFICE

Similarly, in its report to Congress on ways to improve pregnancy outcomes the General Accounting Office recognizes the special contribution of nurse-midwifery care in inner cities and rural areas, and recommends:

> Encourage greater use of nurse-midwife/obstetrician teams.
>
> (Source: United State General Accounting Office. Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome. Washington, DC: U.S. Government Printing Office, 1980.)

JOINT STATEMENT OF PRACTICE RELATIONSHIPS BETWEEN OBSTETRICIAN/GYNECOLOGISTS AND CERTIFIED NURSE-MIDWIVES*

It is critical that obstetrician gynecologists and certified nurse-midwives have a clear understanding of their individual, collaborative and interdependent responsibilities. As agreed upon in previous Joint Statements by the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, and the Nurses Association of the American College of Obstetricians and Gynecologists, the maternity care team should be directed by a qualified obstetrician/gynecologist. The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives believe that the appropriate practice of the certified nurse-midwife includes the participation and involvement of the obstetrician/gynecologist as mutually agreed upon in written medical guideline/protocols. The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives also believe that the obstetrician/gynecologist should be responsive to the desire of certified nurse-midwives for the participation and involvement of the obstetrician/gynecologist. The following principles represent a joint statement of the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives and are recommended for consideration in all practice relationships and agreements.

1. Clinical practice relationship between the obstetrician/gynecologist and the certified nurse-midwife should provide for:
   a. mutually agreed upon written medical guidelines/protocols for clinical practice which define the individual and shared responsibilities of the certified nurse-midwife and the obstetrician/gynecologist in the delivery of health care services;
   b. mutually agreed upon written medical guidelines/protocols for ongoing communication which provide for and define appropriate consultation between the obstetrician/gynecologist and the certified nurse-midwife;
   c. informed consent about the involvement of the obstetrician/gynecologist, certified nurse-midwife, and other health care providers in the services offered;
   d. periodic and joint evaluation of services rendered, e.g. chart review, case review, patient evaluation, review of outcome statistics; and
   e. periodic and joint review and updating of the written medical guidelines/protocols.

2. Quality of care is enhanced by the interdependent practice of the obstetrician/gynecologist and the certified nurse-midwife working in a relationship of mutual respect, trust and professional responsibility. This does not necessarily imply the physical presence of the physician when care is being given by the certified nurse-midwife.

3. Administrative relationships, including employment agreements, reimbursement mechanisms, and corporate structures, should be mutually agreed upon by the participating parties.

4. Access to practice within the hospital setting for the obstetrician/gynecologist and the certified nurse-midwife who have a practice relationship in concurrence with these principles is strongly urged by the respective professional organizations.

The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives strongly urge the implementation of these principles in all practice relationships between obstetrician/gynecologists and certified nurse-midwives, and consider the preceding an ideal model of practice.

*This statement supersedes previous Joint statements of Maternity Care by the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, and the Nurses Association of the American College of Obstetricians and Gynecologists dated 1971 and 1975.

November 1, 1982

The American College of Nurse-Midwives

The American College of Obstetricians and Gynecologists

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National Academy of Sciences, Institute of Medicine, Preventing Low Birthweight, National Academy Press, Washington, D.C., pp. 160 - 161.

Nurse-Midwives and Obstetrical Nurse Practitioners

The committee also considered whether access to prenatal care could be extended by greater reliance on the use of nurse-midwives and nurse practitioners. Certified nurse-midwives (CNMs) are health professionals trained to manage the care of essentially normal women and their newborns during pregnancy, childbirth, and the postpartum/neonatal period. They work in conjunction with physicians, with whom they consult and to whom they refer patients who develop complications or high-risk medical conditions. Although nurse-midwives currently deliver only about 2 percent of the babies born in the United States, they are more active in many other industrialized nations. In Norway, almost 96 percent of pregnant women receive prenatal care and delivery services from midwives; in England, 70 percent do.[30] Nurse practitioners (NPs), quite similar in most respects to nurse-midwives, do not manage intrapartum and immediate postpartum care; their training places greater emphasis on gynecology, but they also provide substantial amounts of prenatal care.

The relevance of such providers to low birthweight prevention derives from the fact that CNMs and NPs have been shown to be particularly effective in managing the care of pregnant women who are at high risk because of social and economic factors.[31] These women often have difficulty communicating effectively with authority figures and may need a great deal of education and support during pregnancy. CNMs and NPs are particularly well-suited to meet such needs. They tend to relate to their patients in a nonauthoritarian manner and to emphasize education, support, and patient satisfaction. Many anecdotal reports suggest that nurse-midwives and nurse practitioners spend more time with their patients than do physicians and are more likely to include counseling and education in their interactions--components of care that are central to prevention of low birthweight (Chapter 8). This general impression is confirmed by a 1981 study that analyzed the content and process of prenatal care provided by CNMs and found significant time spent on teaching during each visit. The mean length of the prenatal visit with the CNM was 23.7 minutes.[32] The 1975 National Ambulatory Medical Care Survey found that prenatal visits with office-based physicians tended to be brief (about 10 minutes) and usually did not include counseling. Thirty-two percent of the patients' visits included no more than 5 minutes with the physician.[33]

One manifestation of the special skills of nurse-midwives and nurse practitioners is the finding of increased "compliance"--i.e. keeping appointments and following specified treatments--among women served by nurse-midwives. For example, in 1976, Slome et al. reported on a randomized clinical trial of nurse-midwifery care as compared to care

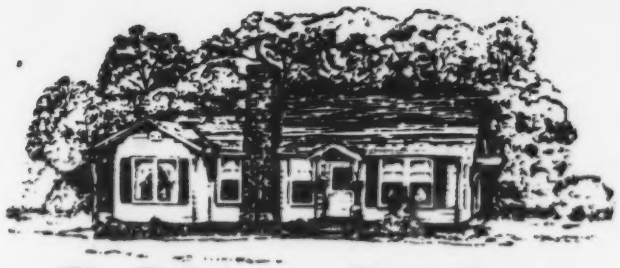
by the obstetric house staff at the University of Mississippi Medical Center. Nurse-midwifery patients kept a sigificantly greater proportion of appointments for prenatal care.[30]

An older study described the impact on prenatal care, prematurity, and neonatal mortality rates of a 3-year demonstration program employing nurse-midwives. From 1960 to 1963, two nurse-midwives managed most normal pregnancies in a county hospital in rural California and delivered 78 percent of the patients. Until the arrival of these CNMs, the area had a major undersupply of maternity care providers. Their presence was associated with an increase in the frequency and regularity of prenatal care visits and a decrease in prematurity and neonatal mortality rates. The discontinuation of the program after 3 years was associated with a reversal of these trends, even though more physicians had by then moved into the area, thereby alleviating the earlier deficit in care providers.[31]

With specific regard to low birthweight, Piechnik and Corbett found a significantly lower incidence of low birthweight among the infants of pregnant adolescents cared for by a multidisciplinary team (medicine, nurse-midwifery, nutrition, social work, and nursing, with CNMs managing the case load and seeing each patient at every prenatal visit), than among a matched control group who received prenatal care through state-supported maternal and child care clinics. Patients in both groups were of low socioeconomic status. The low birthweight rate of the nurse-midwife group was 28 percent less than that of the control group. Among adolescents under age 15, the nurse-midwife patients' low birthweight rate was 50 percent lower than that of the control group.[32]

CNM services are important to low birthweight prevention for another reason. In the United States, CNMs serve disproportionate numbers of women who are poor, adolescent, members of minority groups, and residents of inner cities or rural areas,[33] the same groups in which low birthweight rates are often elevated. In selected communities, they have developed specialized maternity care services to meet the needs of socially and economically high-risk women. In recognition of such factors, the committee recommends that:

> More reliance should be placed on nurse-midwives and nurse practitioners to increase access to prenatal care for hard-to-reach, often high-risk groups. Maternity programs designed to serve socioeconomically high-risk mothers should increase their use of such providers; and state laws should be supportive of nurse-midwifery practice and of collaborations between physicians and nurse-midwives/nurse practitioners.



The Tallahassee Birth Centre

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STUDY DETERMINES BIRTH CENTERS SAFE, SENSITIVE AND AFFORDABLE

A nationwide study shows birth centers provide a safe alternative to hospital childbirth for healthy women with normal pregnancies. The New England Journal of Medicine published the results of approximately 12,000 women admitted for labor and delivery at 84 birth centers from 1985 to 1987.

The large prospective study, reported by the Columbia University School of Public Health, states, "Few health service innovations give simultaneous promise of lower cost, greater availability, and high satisfaction with equal safety. The results of this study suggest that modern birth centers can identify a group of women who are a low risk for obstetric complication and can care for them in a way that provides these benefits."

Many of Florida's birth centers participated in this study. The Tallahassee Birth Centre was one of them. Now in it's seventh year and close to 400 births the Tallahasssee Birth Centre continues it's proud "safe and sensitive care".

Florida has long reconized the safety and cost effectiveness of birth centers. Since 1984 Florida has had licensure and regulation for birth centers. The legal definition of a birth center is "any facility, institution or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy."

The Florida Health Care Cost Containment Board has recently published a brochure about the cost effectiveness of birth centers.(see article)

Florida has recently passed legislation for reimbursement of birth center care by all insurance companies and health maintenance organizations.(see article)

NEW LEGISLATION

SAVE THE MIDWIVES! Licensed Midwives need your help.

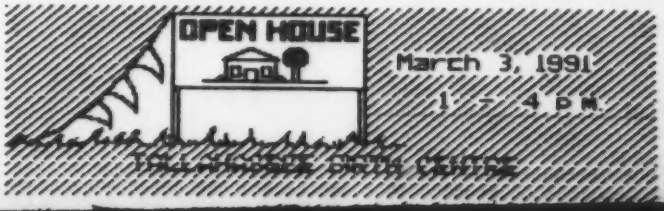
The 1990 Legislature passed a bill mandating a study of midwifery. This progressive step was successful because of all the consumer support. The many groups of Friends of Midwives are to be commended on their committment to midwifery as a safe option for birthing women.

As the 1991 legislative session draws near, once again the strategy needs to be developed and put into place. This year will prove to be the most challenging the midwives and consumers have ever faced. During the interim time there have been three workshops on midwifery held. Participants have been from all areas - obstetrics, pediatrics, nurse midwifery, licensed midwifery, hospitals and consumers. Many areas of agreement and concern have been addressed.

The Senate and House Health Care Committees are conducting the study and have sent out a survey to be compiled and a report written to present to your elected officials.

Your support in letters, phone calls and personal visits is critical. If midwifery is to remain safe and regulated by the state the legislature must know there are consumers wanting birth center and home birth options with licensed midwives. Please contact your legislators, members of the Senate and House Health Care Committees and their staff and Governor-Elect Chiles (the Tallahassee Birth Centre delivered his grand-daughter). Make your letters short and in your own words tell them why you want to have licensed midwives available to you, your family, friends and community.

Call the Birth Centre for more information and to volunteer to help at this most important time.



President's Corner

by Beth Swisher

As the saying goes "Time flies when you're having fun". Well that is exactly what has been happening at the Tallahassee Birth Centre.

October 1990 saw the seventh year for the Birth Centre. One of the upcoming events we are all looking forward to is the delivery of our 400th baby! We are anticipating the event after the first of the year. In celebration the Birth Centre will be hosting an open house on March 3, 1991. We would love to have some help and input for this exciting adventure. Please call with any ideas or offers of help.

Speaking of volunteers, you will find enclosed in this issue of the newsletter a volunteer sheet. (In fact one of the goals is to provide you with a REGULAR newsletter, for which we need help.) A special thanks to all those who helped get this one together. We value all our supporters and would really appreciate anything you would like to do to help promote the Birth Centre. So don't be left out!! Fill out the form and send it back.

You will find in this newsletter information about the Friends of Midwives that recently formed. They are doing an admirable job. I would like to personally thank all of the wonderfully committed, dedicated people in this organization for all the time, energy and money they have already expended and will continue to expend for the cause of midwifery. Be sure to read all the events and news the Friends of Midwives is reporting in this issue.

Let me close by wishing your family a safe and secure season, and inviting all of you to come by during the holidays to view our traditional decorations.

AT A GLANCE

BIRTH SERVICES

*Free tour & consultation
*Comprehensive prenatal care
*Nutrition counseling
*Bradley childbirth classes
*Prenatal lab work
*Personalized birth plan
*Labor and delivery
*Postpartum care

GYNECOLOGICAL SERVICES

*Annual physical exams
*Breast exams
*Birth Control Services
  -Cervical cap fittings
  -Diaphragms
  -Oral contraceptive
*Natural family planning
*Prepregnancy counseling
*Gynecological care

BIRTH CENTRE BENEFITS

$ $ $ $ COSTS $ $ $ $

Birth Centers offer many wonderful features, not the least being that of cost effectiveness. In the Health Insurance Association of America publication the average cost of having a baby was $4,335 in 1989. At the Tallahassee Birth Centre the total cost is $2,100 for 1990. This includes all prenatal care, rountine laboratory services, childbirth classes, use of the lending library, labor & delivery, and postpartum care. The Tallahassee Birth Centre accepts insurance coverage, HMO coverage, Medicaid, and has funding from the state for financially qualified clients.

TALLAHASSEE BIRTH CENTRE STATISTICAL UPDATE

Total registered clients:	601	100.0%
Total admitted clients:	435	72.4%
Total births at centre:	346	79.5%
Transfers in labor:	89	20.5%
Transfers of mother - postpartum:	3	.69%
Transfers of newborn:	4	.92%
Vaginal deliveries:	410	94.3%
Cesarean sections:	25	5.7%
Episiotomy:	13	2.99%

Average Length of Stay:
Admission to discharge: 7.55 hours
From birth to discharge: 3.79 hours

Range of Stay:
Admission to discharge: 2 - 35 hrs.
From birth to discharge: 2 - 23 hrs.

Maternal mortality: 0
Perinatal mortality: 0
(July 1984 - June 1990)

GUIDE TO CHARGES AT BIRTH CENTERS IN FLA

The Florida Health Care Cost Containment Board released its newest brochure in July of this year. It was an exciting event for birth centers all over Florida. The brochure lists all the birth centers, their addresses, phone numbers, charges, number of deliveries, average number of visits, if they take Medicaid and other valuable information. Much of the information came from Florida's law regarding birth centers, the national study that was published in the New England Journal of Medicine, and a survey of every birth center in Florida.

Come by the Tallahassee Birth Centre or call 1-800-342-0828, the toll free number of the Health Care Cost Containment Board, for your copy.

The Loving Touch Cookbook

Let us solve your holiday gift giving dilemma. "The Loving Touch Cookbook" is the perfect gift for relatives, teachers, mailperson, and special friends.

This exceptional value ($5.00 donation) has 200 family favorite recipes and was compiled by the Friends of Midwives. So make holiday shopping easy on yourself while you support midwifery in Florida.

We have a good supply of cookbooks at the Tallahassee Birth Centre or ask any North Florida Friends of Midwive's member for a copy.

North Florida Friends of Midwives

formed in 1989

We are women and men who have come together to preserve our right to choose the extent of medical intervention in labor and birth, the type of birth attendant and the setting. We are working to reinstate the Midwifery Practice Act to its original intent. This would allow the profession of midwifery to grow, to continue providing safe alternatives for birthing women and to help solve the ever increasing shortage of maternity care in Florida.

STATEMENT OF PURPOSE

1. Safeguarding the option of birth center and home birth with midwives in Florida.

2. Educating and informing our community of their options in birthing and well-woman care.

3. Supporting cost-effective birth alternatives for all pregnant women.

4. Supporting direct-entry midwifery training programs in Florida.

. Supporting legislation that allows midwives to practice their profession with licensing by the state of Florida.

We meet monthly at the Tallahassee Birth Centre and would like to invite your participation in our organization. Please be sure to attend Kidfest '90.

HMO NOW COVERS BIRTH CENTERS

Now your HMO (health maintenance organization, Capital Health Plan, and Health Plan Southeast and others) MUST cover your pregnancy care at the Tallahassee Birth Centre. October 1, 1989 Florida Statue 627.31 took effect which states "Health maintenance contracts which provide coverage, benefits, or services for maternity care shall provide, as an option to the subscriber, the services of nurse-midwives and midwives licensed pursuant to chapter 467, and the service of birth centers licensed pursuant to ss. 383.30-383.335."

Call the Birth Centre for further information. (This legislation also covers all group health insurance with maternity benefits.)

NATIONAL STUDY STATISTICS

The following statistics indicate that birth centers are a safe birthing alternative:

*Of women who gave birth in centers, 99.4% had spontaneous vaginal deliveries.
*The rate of cesarean section was 4.4%.
*The average number of prenatal visits was 11.2.
*Only 2.4% has emergency transfers.
*The overall intrapartum and neonatal mortality rate was 1.3 per 1000 births.
*The rate of infant mortality and low Apgar scores were similar to those reported in large studies of low-risk hospital births.
*Of women in labor at birth centers, 97% were accompanied by friends or family members, often including young children. Of the women receiving care during labor and birth at birth centers and completing evaluations, 98.8% stated that they would recommend the center to friends and 94% indicated that they would use the birth center in another pregnancy.

WHAT'S IN A NAME?

As you must have noticed the lack of a name for our newsletter. Please call the Birth Centre with your ingenious creations. Thanks!!

HALLOWEEN 1990
saw a change of staff at the
Birth Centre!

A HEART FELT THANKS

Merci beaucoup

Gracias

Grazie

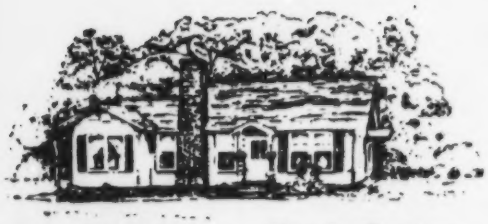
Thank you Danke Schoen

TO ALL THAT HELPED AT THE FAIR!

CALENDAR:

Thursday - Free orientation and Birth Centre tour 8:00 p.m. (weekly)
December - Legislative committee meeting
January - Legislative committee meeting
February - Legislative committee meeting

*December 7 - Friends of Midwives at the City of Lights
*December 15 - Friends of Midwives Kidfest '90
*March 3 - Birth Centre Open House
*March 5 - 1991 Legislative session begins



The Tallahassee Birth Centre
260 East Sixth Avenue
Tallahassee, Florida 32303

Bulk Rate
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Tallahassee, FL
Permit 236

The American College
of Nurse Midwives
1522 K Street, NW
Suite 1120
Washington, DC 20005

Today's Certified Nurse-Midwives

Today, more and more women are turning to America's certified nurse-midwives to guide them through their pregnancies, deliver their babies, care for them after childbirth, and provide normal ongoing gynecology services.

WHAT IS A CERTIFIED NURSE-MIDWIFE?

A certified nurse-midwife is a registered nurse with advanced training who cares for women and their infants during the childbearing years. To become certified, the nurse-midwife must complete a course of study in an accredited educational program, and pass a rigorous examination administered by the American College of Nurse-Midwives. State requirements for nurse-midwifery must also be met.

For centuries, women have looked to midwives to advise and assist them in childbirth. Today's certified nurse-midwife carries on this tradition of personal, family-centered, understanding care. In addition, today's nurse-midwife is also a highly skilled health professional, able to draw on the vast resources of modern medicine to give patients the best care possible.

Although certified nurse-midwives independently manage the care of healthy women and newborns, each nurse-midwife is affiliated with a physician, who is available for consultation or referral if needed.

PERSONAL, ONGOING CARE FOR WOMEN AND NEWBORNS

Before and after pregnancy, the nurse-midwife advises you about reproductive health, conception and personal care, and provides regular gynecological services, such as yearly pelvic and breast exams and pap smears. Healthy post-menopausal women also can use the services of a nurse-midwife.

During pregnancy, the nurse-midwife monitors your health and that of your baby. Your nurse-midwife will also answer any questions you have and provide education on nutrition, exercise, childbirth methods, infant health and what to expect as a parent.

During labor, the nurse-midwife evaluates the progress of labor and offers you ongoing emotional and physical support. You can expect your nurse-midwife to make every effort to facilitate the natural processes of labor and to involve your family in the delivery process as you wish. Should the course of labor deviate from the normal, the nurse-midwife will consult with the back-up physician.

At birth, the nurse-midwife assists you throughout delivery, examines your newborn, and helps you and your family in welcoming your new baby.

After delivery, the nurse-midwife provides you with follow-up care and offers advice on self-care, breast or bottle feeding and infant care.

CHOOSING A NURSE-MIDWIFE

More and more women are finding that nurse-midwifery services are a safe, sensitive and personal form of health care. Any woman who is in generally good health can take advantage of the services of a nurse-midwife throughout and beyond her childbearing years.

A CHOICE OF SETTINGS

Nurse-midwives typically work in hospitals, birthing centers, health maintenance organizations, public health departments, private practices and clinics. Usually, nurse-midwives deliver babies in hospitals or birthing centers. Some nurse-midwives deliver babies in the home if certain safety criteria are met.

REIMBURSEMENT

Nurse-midwifery services are covered by most private medical insurance carriers. Services are also covered under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicaid.

A SIXTY-YEAR TRADITION

Nurse-midwifery had its beginnings in the United States in eastern Kentucky in the 1920s. For the first time, women in rural, mountainous areas could obtain the services of a specially trained registered nurse sent by the Frontier Nursing Service.

Over the next fifty years, nurse-midwives built their tradition of professional, affordable maternal and infant care. Then, in the early 1970s, interest in natural childbirth began to grow and childbearing families began to seek the personalized care of nurse-midwives. Some nurse-midwives began setting up birthing centers that combined the safety of hospital care with the comfort of a homelike setting.

Today, more than 2500 certified nurse-midwives practice in all 50 states and in many other countries around the world.

AN OUTSTANDING RECORD

Over the years, nurse-midwives have maintained a superb record of safety and client satisfaction. They have also made a significant contribution to healthier births. A recent report by the Institute of Medicine points out that nurse-midwives are particularly effective in managing the care of pregnant women, and that such care results in fewer premature and underweight babies.

For More Information

To find out more about nurse-midwifery services available in your area or for a listing of accredited university-affiliated nurse-midwifery education programs, contact:

The American College of Nurse-Midwives
1522 K Street NW
Suite 1120
Washington, DC 20005
(202) 347-5445

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Certified nurse-midwives offer professional, yet personalized, care that takes into account the physical, social and spiritual needs of each woman. They are committed to close patient rapport, ongoing patient and family education, and promotion of individual responsibility for health.

Their commitment has a solid foundation. All certified nurse-midwives are registered nurses who have completed an additional educational program in midwifery. They are specialists in the care of healthy women and newborns.